In a 22 year career of Neurosurgery I have participated in many agonizing talks with families and patients about how far to treat and how to minimize pain. Families often confuse their pain with the patient's.

Last year one person in their twenty's, presented to our E.R. in coma after a suicide attempt. Kidneys, lungs, liver, and heart were failing. Brain damage was likely, but unknown. Given their youth, all the stops were pulled out to try and rescue this person. I saw the intensive care specialist try treatments, I had not even heard of previously. The vital organs stabilized, the brain scans looked "ok", but they were not waking up.

Then the family asked us to stop treatment to withdraw the things keeping the body going while the brain had time to hopefully wake up. When asked why - they responded - - 'if this person wakes up and is mad and tries suicide again, we don't want to go through this again, they would not want all this, we can't go through this anymore'.

It was impossible to sort out. What motivated them more? Was it the desire to avoid their own personal suffering or were they truly reflecting what the patient would consent to? They did not appear to even see the distinction; much less make an objective choice. Finally, after hours of conversation, they decided that if they were to make an error it would be on the side of life. Weeks later that patient walked out of the hospital happy and smiling. Will the patient attempt suicide again? Maybe, but the patient was glad for another chance and hopeful.

Or there was the brain surgery patient whose wife insisted I disconnect everything and give him morphine so that he would die peaceably, unless I could guarantee a 100% recovery. She insisted this is what he would want, even though he told me he wanted treatment and surgery, even if risky. They divorced less than a year after he walked out of the hospital. She has since died; he is alive and independent. When I ask him if he would have preferred we let him die he answers "#@ no".

Or there is the stroke patient who was a young man when he went into a coma. Most of his doctors thought further treatment futile. His wife said his three young daughters just wanted him to read a story to them on Christmas day. His treatment, and tubes, and problems, and coma went on and on. Yet on Christmas morning when I walked into the ICU he was sitting in bed, eyes open, reading a word or two as his wife read and turned most of the pages and his three daughter sat in bed with him with big smiles. His recovery continued. He is still working as a salesman and his daughters are grown. There is a drawing in the ICU of a man reading to three little girls, that was a gift from the family.

In each of these three cases it would have been possible to find two physicians who would have declared these patients as terminal. And it would have been possible to find at least on family member who wanted treatment to stop. Each would have met the exit criteria of most "physician assisted suicide" advocates and laws.

Do we sometimes treat too much? Of course. Do we sometimes have difficulty knowing whether we are prolonging life or prolonging the act of dying? Yes.

That only emphasizes the point that physicians are often wrong in their prognosis. And families and doctors may not be able to sort out weather a "spokesperson" is truly

speaking for the patient, projecting their own suffering onto the patient, or simply motivated by unspoken agendas.

It is hard enough now. Even if we could ignore the big ethical issues, the future is sure to include increasing medical capabilities and increasing financial limits. I can already ease the suffering; that ability will only increase. Most of the dignity and suffering issues we see now are due to ignorance or failure to address openly. Please do not give us the power to kill. If you must err, do so on the side of life.

Paul Gorsuch, M.D.

On Physician Assisted Suicide

There are basic issues like is it "ok" to license one group of citizens (physicians) to kill another group (qualifying patients). Or why limit physician assisted suicide to the "terminally ill" or suffering? What is the basis for not extending the same service to anyone wishing to die? Some current advocates of "physician assisted suicide" are already arguing that such a "right" should not be limited to the dying. But even if we ignore these big issues and their implications there are a lot of other problems.